STATE OF MONTANA
Department of Public Health and Human Services

HCBS 899-9

HOME AND COMMUNITY BASED SERVICES
ADULT RESIDENTIAL CARE CALCULATION

Consumer Name: _____ Medicaid # : _____ A Bed ____

Facility Name: _____ PCF _____ B Bed ____

AFH _____ C Bed ____

(A) Room & Board (R&B) — The amount for R&B is set by DPHHS, but collected from the consumer by the facility.

(B) Service Package — The basic service amount established by DPHHS.

(C) Support Services — Support service rate is based upon individual needs & established by the case management team for DPHHS. If the need is met or the facility does not provide the service, enter 0. The facility must provide the service listed below.

	LOC Score		LOC Score
Bathing		Housekeeping	
Personal Hygiene		Money Management	
Dressing		Socialization	
Toileting		Transportation	
Medication Management		Communication	
Medical Management		Behavior Management	
Mobility		Impaired Judgment	
Transfers		Memory Cueing	
Eating		Time Management	
Diet		Other	
Exercise		Other	
Total LOC Score		x $__	

SCORING KEY

0 = Independent - includes assist from family or others or need is met.

1 = Minimal Assist - set up help, prompting.

2 = Direct Assist - with active participation of individual to complete task.

3 = Extensive Assist - with limited participation of individual to complete task.

4 = Total Dependence - with no participation of individual to complete task.

(D) (A+B+C)

(E) Facility Private Pay Rate

(F) Total to facility is the lesser of D or E
(See instructions on back of form for maximum limit)

The following outlines the responsibility of payment to the facility:

Daily Rate Computation **Effective Date** _____

(A1) Room & Board

(A2) Consumer Contribution (see instructions on back)

(A3) Other _____

(G) Subtotal of consumer responsibilities: **(A1+A2+A3)**

Daily Rate

(H) Daily Rate: (F-G) Divided by 30 Days

(I) Medicaid Responsibility Daily rate is billable day _____ through the end of the month

Incurment Section

(A4) Incurment used for AR services — divided by (H) Daily Rate - _____ Day incurment is met

(J) Total Consumer Responsibility: **(G + A4)**

Provider Signature: _____ Date _____

CMT Signature: _____ Date _____